GEORGIA STATE BOARD OF NURSING HOME ADMINISTRATORS
237 Coliseum Drive
Macon, Georgia 31217-3858
(478) 207-2440 (Telephone)
http://sos.ga.gov/plb/nursinghome

APPLICATION FOR APPROVED PRECEPTOR FOR A NURSING HOME "ADMINISTRATOR-IN-TRAINING" PROGRAM

INSTRUCTIONS ***PLEASE TYPE OR PRINT CLEARLY IN INK.***

Where the space provided is not sufficient, attach additional sheets.

- Enclose Application Fee of $75.00 by check or money order payable to "Georgia State Board of NHA". **Checks returned for insufficient funds will be assessed a service charge pursuant to O.C.G.A. §16-9-20.**
- To be approved as a Preceptor, the Applicant must be a nursing home administrator at an approved site or have attached AIT Site application with this application, currently licensed in Georgia, employed and working fulltime at the nursing home and have been employed as a licensed nursing home administrator for a minimum of five (5) years. Provide proof by submitting Form A or a letter(s) verifying employment for three (3) years. Approval is valid for three (3) consecutive years, unless withdrawn by the Board. See Board Rules, Chapters 393-4-.01and 393-4-.02.

NAME: _____
Last First Middle Maiden

HOME ADDRESS:_____
Street City State Zip Code

BUSINESS ADDRESS:_____
Street City State Zip Code

CHECK PREFERRED MAILING ADDRESS:___ HOME ___ BUSINESS

HOME PHONE: (____) _____ BUSINESS PHONE: (____) _____ FAX: (____) _____

EMAIL ADDRESS:

DATE OF BIRTH: _____ *SOCIAL SECURITY #: _____
MONTH/DAY/YEAR

*This information is authorized to be obtained and disclosed to state and federal agencies pursuant to O.C.G.A. 19-11-1 and O.C.G.A. 20-3-295, 42 U.S.C.A. 551 and 20 U.S.C.A. 1001. It may also be disclosed to the National Practitioner's Databank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) or other licensing boards, or other regulatory agencies for license tracking purposes.

PART I – PRECEPTOR QUALIFICATIONS

GEORGIA NHA LICENSE #: _____ ISSUANCE DATE: _____

DOCUMENT FIVE (5) YEARS OF EXPERIENCE AS A LICENSED NURSING HOME ADMINISTRATOR

From: _____ To: _____ Year(s): _____ Month(s):_____

INDICATE EACH FACILITY WHERE YOU HAVE PRACTICED AS AN ADMINISTRATOR:

1. Name of Nursing Home: _____

Address: _____

From: _____ To:_____ Year(s): _____ Month(s):_____

2. Name of Nursing Home: _____

Address: _____

From: _____ To:_____ Year(s): _____ Month(s): _____

(Use an additional Sheet if needed)

PART II – PROFESSIONAL BACKGROUND

INSTRUCTIONS: If you answer "Yes" to any of the following questions, **attach an explanation, relevant documents and a description of the current status.** For the purpose of the following questions, the terms "license," "registration," and "certification" are synonymous.

___Yes ___No Have you been approved in the past as a Preceptor? If "Yes", please explain [Site, Date/s, etc.]

___Yes ___No Do you now hold, or have you in the past held a professional license? If "Yes," complete the following and attach additional sheets, if necessary.

License Title _____

State _____ Date Issued _____ Expiration Date _____

License Title _____

State _____ Date Issued _____ Expiration Date _____

___Yes ___No Have you had revoked or suspended or otherwise sanctioned any license issued to you by any board or agency in Georgia or any other state?

___Yes ___No Were you denied issuance of or, pursuant to disciplinary proceedings, refused renewal of a license or the privilege of taking an examination by any state licensing board?

___Yes ___No Have you knowingly failed to renew a license during an investigation of disciplinary action?

___Yes ___No Have you been subject to disciplinary action or had your membership revoked by a professional organization governing the practice of that profession?

___Yes ___No To the best of your knowledge, is there any disciplinary action pending against you by any licensing board or professional organization?

___Yes ___No Have you been arrested, charged or sentenced for the commission of a felony or any crime involving moral turpitude?

___Yes ___No Are you currently **unable** to practice with reasonable skill and safety by reason of illness or use of alcohol, drugs, narcotics, chemicals or any other type of material, or as a result of any mental or physical condition?

___Yes ___No Have you had any suit filed against you related to the practice of a profession?

___Yes ___No Have you ever had your Medicaid and/or Medicare privileges revoked or restricted?

___Yes ___No Have you ever been convicted of a felony or misdemeanor (other than a traffic violation), entered a plea of guilty or nolo contendere, or entered a plea under a first offender provision?

PART III - A.I.T. APPROVED SITE(S)

Please indicate the name of the approved site where you will be a preceptor in the first section. Please indicate any other approved sites for which you have ever been a preceptor.

AIT APPROVED SITE

NAME OF SITE WHERE YOU WILL BE PRECEPTOR:

ADDRESS:_____
Street City State Zip Code

PHONE: ( ) FAX: ( )

AIT APPROVED SITE: Other facility where you were the licensed preceptor

NAME:

ADDRESS:_____
Street City State Zip Code

PHONE: ( ) FAX: ( )

AIT APPROVED SITE: Other facility where you were the licensed preceptor

NAME:

ADDRESS:_____
Street City State Zip Code

PHONE: ( ) FAX: ( )

Georgia State Board of Nursing Home Administrators
237 Coliseum Drive, Macon, Georgia 31217-3858
Phone: 478-207-2440
www.sos.state.ga.us/plb/nursinghome

AFFIDAVIT OF EXPERIENCE – **FORM A**

- Please type or print legibly
- Complete a form for each employer in order to meet **the required nursing home** experience for your application**.**
- Applicant **completes Part I**
- Owner/Administrator of the nursing facility or the employer/superior in the chain of command at the home office that operates the licensed nursing facility and/or hospital **completes Part II**

PART I – APPLICANT

Applicant's Name_____

Name of business or corporation that owns facility:

_____

Name of facility_____

Address of facility_____
Street **City** **State** **Zip**

Phone number of facility_____ **Position held**_____

Dates employed— From: _____ _____ To: _____
Month/Year **Month/Year**

Description of Responsibilities:

_____

_____

_____

_____

_____

_____

Affidavit

I, the above Applicant, attest that the above information is a true and accurate representation of experience obtained in a nursing facility or home office that operates licensed nursing facilities or hospitals.

_____ _____
Date Signature of Applicant

PART II – OWNER/ADMINISTRATOR/EMPLOYER/SUPERIOR

Instructions

- **Please review the applicant's description of <u>nursing home</u> experience**
- **Please submit comments or any additional information that will assist the Board in its decision for licensure for the applicant**

Comments_____

_____

_____

_____

_____

_____

I, the undersigned ___ Owner/Administrator of the nursing facility, or, ___ Employer or Superior in the chain of command at the home office that operates licensed nursing facilities and/or hospitals, attest that the description provided by the Applicant of the experience obtained in a nursing facility, home office of a business or corporation that operates licensed nursing facilities or hospitals, is true and accurate, and I further acknowledge that I may be required to furnish additional information promptly for this application to be processed.

_____ _____

Date **Signature of Nursing Home Administrator/Employer**

Subscribed and sworn to before me this

_____day of _____20_____

_____

Notary Public

My Commission Expires_____

Notary Seal

DUTIES OF PRECEPTOR:
(PLEASE KEEP THIS SHEET FOR YOUR RECORDS)

Board Rule: 393-4-.02 – The preceptor is solely responsible for ensuring that the AIT complies with the Laws and Rules of the Board, and must attest to such compliance upon completion of the AIT program.

The preceptor must ensure that the AIT is not over-burdened with routine responsibilities that may be detrimental to his or her training, and must ensure that the intern is afforded a broad and comprehensive experience.

A monthly report is to be submitted to the Board beginning 30 days from the starting date of the AIT program. This report must follow the individualized schedule and describe the activities of the month and should be signed and notarized by both the Preceptor and the AIT. If AIT does not submit reports showing proper hours worked, a denial will be issued. If time off is granted during AIT, it must not affect the completion of the program and it must be documented on the monthly reports.

Supervision Chart

The AIT program may be Full Time or Part Time. Will your program be on a full time basis (40 hours per week) _____, or, on a part time basis (no less than 24 hours per week)? ____

Full Time or Part Time	Check next to Length of Program Required
Full Time = 40 hours/wk 500 hours = 12.5 weeks @ 40 hrs. 1000 hours = 25 weeks @ 40 hrs. 2000 hours = 50 weeks @ 40 hrs.	1. 500 Hours ____ 3 months license 2. 1000 Hours ____ 6 months license 3. 2000 Hours ____ 12 months license
Part Time = 24 hours minimum/wk 500 hours = 20.83 weeks @ 24 hrs. 1000 hours = 41.66 weeks @ 24 hrs. 2000 hours = 83.33 weeks @ 24 hrs.	1. 500 Hours ____ 3 months license 2. 1000 Hours ____ 6 months license 3. 2000 Hours ____ 12 months license
An AIT License is issued for a **3 month, 6 month or 12 month (1 year) period**. Written request for an extension must be submitted at least 30 days before license expires. Approval of reports or extensions is at the Board's discretion.	The **AIT outline** form must be submitted for **each** individual you are supervising. This form should be submitted with the AIT application.

Please submit the **CERTIFICATION OF PROGRAM COMPLETION FORM to the Board with the final report due. This form must be received by the Board. No approvals will be provided for licensure until the completion form is received and approved by the Board.**

Please keep copies of all approval/denial letters from the Board. It is the responsibility of the preceptor and the AIT to keep track of the total hours approved by the Board.

Georgia Board of Nursing Home Administrators

237 Coliseum Drive, Macon, GA 31217 * (478) 207-2440

AIT PROGRAM OUTLINE - 500 HOUR

****Preceptor: Please indicate below your established plan for the AIT training.**

(Please print **clearly** or type all answers - if there is not sufficient space, use additional sheets and number accordingly).

NAME OF AIT: _____ Date _____
(Title) (Last) (First) (Middle)

NAME OF FACILITY WHERE TRAINING IS TAKING PLACE: _____

ADDRESS: _____

TELEPHONE: _____ FAX: _____

Proposed AIT Beginning Date: _____ Proposed date of Completion: _____

RESIDENT CARE AND QUALITY OF LIFE: (A minimum of 200 hours) TOTAL HOURS _____
Topics in this area should include nursing services, social services, food service, medical services, therapeutic services, recreational and activity programs, medical records, pharmaceutical program and rehabilitation services.

NURSING	_____	SOCIAL SERVICES	_____
DIETARY	_____	RECREATION/VOLUNTEERS	_____
MEDICAL RECORDS	_____	REHABILITATION SERVICES	_____
MEDICAL/ALLIED HEALTH	_____	PHARMACEUTICAL PROGRAM	_____

HUMAN RESOURCES: (A minimum of 80 hours) TOTAL HOURS _____
Topics in this area should include recruitment, interviewing, employee selection, training, personnel policies, employee health and safety program, and employee retention.

ADMINISTRATION _____

FINANCE: (A minimum of 65 hours) TOTAL HOURS _____
Topics in this area should include accounting, budgeting, financial planning and asset managing, and auditing.

BUSINESS _____

PHYSICAL ENVIRONMENT: (A minimum of 40 hours) TOTAL HOURS _
Topics in this area should include safety procedures, fire, disaster and emergency programs, and building and environmental management.

HOUSEKEEPING/LAUNDRY _____ MAINTENANCE _____

LEADERSHIP AND MANAGEMENT: (A minimum of 90 hours) TOTAL HOURS _____
Topics in this area should include compliance with laws and regulations and governing entities, risk management, communication, survey, certification, enforcement, quality improvement models and management information systems.

OTHER: _____ **TOTAL HOURS** _____

TOTAL NUMBER OF HOURS IN AIT TRAINING PROGRAM _____

TO BE COMPLETED BY THE SUPERVISING LICENSED NURSING HOME ADMINISTRATOR: I certify that the AIT whose signature appears below has agreed to complete this AIT program of **500** hours under my personal supervision.

_____
(Signature of Preceptor)

GA NHA License # _____

_____
(Signature of AIT)

Georgia Board of Nursing Home Administrators

237 Coliseum Drive, Macon, GA 31217 * (478) 207-2440

AIT PROGRAM OUTLINE - 1000 HOUR

****Preceptor: Please indicate below your established plan for the AIT training.**

(Please print **clearly** or type all answers - if there is not sufficient space, use additional sheets and number accordingly).

NAME OF AIT: _____ Date _____
(Title) (Last) (First) (Middle)

NAME OF FACILITY WHERE TRAINING IS TAKING PLACE: _____

ADDRESS: _____

TELEPHONE: _____ FAX: _____

Proposed AIT Beginning Date: _____ Proposed date of Completion: _____

RESIDENT CARE AND QUALITY OF LIFE: (A minimum of 320 hours) TOTAL HOURS _____
Topics in this area should include nursing services, social services, food service, medical services, therapeutic services, recreational and activity programs, medical records, pharmaceutical program and rehabilitation services.

NURSING _____ SOCIAL SERVICES _____

DIETARY _____ RECREATION/VOLUNTEERS _____

MEDICAL RECORDS _____ REHABILITATION SERVICES _____

MEDICAL/ALLIED HEALTH _____ PHARMACEUTICAL PROGRAM _____

HUMAN RESOURCES: (A minimum of 150 hours) TOTAL HOURS _____
Topics in this area should include recruitment, interviewing, employee selection, training, personnel policies, employee health and safety program, and employee retention.

ADMINISTRATION _____

FINANCE: (A minimum of 150 hours) TOTAL HOURS _____
Topics in this area should include accounting, budgeting, financial planning and asset managing, and auditing.

BUSINESS _____

PHYSICAL ENVIRONMENT AND ATMOSPHERE: (A minimum of 80 hours) TOTAL HOURS _
Topics in this area should include safety procedures, fire, disaster and emergency programs, and building and environmental management.

HOUSEKEEPING/LAUNDRY _____ MAINTENANCE _____

LEADERSHIP AND MANAGEMENT: (A minimum of 200 hours) TOTAL HOURS _____
Topics in this area should include compliance with laws and regulations and governing entities, risk management, communication, survey, certification, enforcement, quality improvement models and management information systems.

OTHER: _____ **TOTAL HOURS** _____

TOTAL NUMBER OF HOURS IN AIT TRAINING PROGRAM _____

TO BE COMPLETED BY THE SUPERVISING LICENSED NURSING HOME ADMINISTRATOR: I certify that the AIT whose signature appears below has agreed to complete this AIT program of **1000** hours under my personal supervision.

_____
(Signature of Preceptor)

GA NHA License # _____

_____
(Signature of AIT)

Georgia Board of Nursing Home Administrators

237 Coliseum Drive, Macon, GA 31217 * (478) 207-2440

AIT PROGRAM OUTLINE - 2000 HOUR

****Preceptor: Please indicate below your established plan for the AIT training.**

(Please print clearly or type all answers - if there is not sufficient space, use additional sheets and number accordingly).

NAME OF AIT: _____ Date _____
(Title) (Last) (First) (Middle)

NAME OF FACILITY WHERE TRAINING IS TAKING PLACE: _____

ADDRESS: _____

TELEPHONE: _____ FAX: _____

Proposed AIT Beginning Date: _____ Proposed date of Completion: _____

RESIDENT CARE AND QUALITY OF LIFE: (A minimum of 750 hours) TOTAL HOURS _____
Topics in this area should include nursing services, social services, food service, medical services, therapeutic services, recreational and activity programs, medical records, pharmaceutical program and rehabilitation services.

NURSING _____ SOCIAL SERVICES _____

DIETARY _____ RECREATION/VOLUNTEERS _____

MEDICAL RECORDS _____ REHABILITATION SERVICES _____

QUALITY IMPROVEMENT _____ PHARMACEUTICAL PROGRAM _____

HUMAN RESOURCES: (A minimum of 250 hours) TOTAL HOURS _____
Topics in this area should include recruitment, interviewing, employee selection, training, personnel policies, employee health and safety program, and employee retention.

ADMINISTRATION _____

FINANCE: (A minimum of 250 hours) TOTAL HOURS_____
Topics in this area should include accounting, budgeting, financial planning and asset managing, and auditing.

BUSINESS _____

PHYSICAL ENVIRONMENT: (A minimum of 250 hours) TOTAL HOURS _____
Topics in this area should include safety procedures, fire, disaster and emergency programs, and building and environmental management.

HOUSEKEEPING/LAUNDRY _____ MAINTENANCE _____

LEADERSHIP AND MANAGEMENT: (A minimum of 400 hours) TOTAL HOURS _____
Topics in this area should include compliance with laws and regulations and governing entities, risk management, communication, survey, certification, enforcement, quality improvement models and management information systems.

OTHER: _____ **TOTAL HOURS** _____

TOTAL NUMBER OF HOURS IN AIT TRAINING PROGRAM _____

TO BE COMPLETED BY THE SUPERVISING LICENSED NURSING HOME ADMINISTRATOR: I certify that the AIT whose signature appears below has agreed to complete this AIT program of **2000** hours under my personal supervision.

_____
(Signature of Preceptor)

GA NHA License # _____

_____
(Signature of AIT)

Georgia Board of Nursing Home Administrators

237 Coliseum Drive, Macon, GA 31217 * (478) 207-2440

CERTIFICATION OF PROGRAM COMPLETION – 500 HOUR PROGRAM

(Please print clearly or type all answers - if there is not sufficient space, use additional sheets and number accordingly).

NAME: _____ Date _____
(Title) (Last) (First) (Middle)

NAME OF FACILITY WHERE TRAINING IS TAKING PLACE: _____

ADDRESS: _____

TELEPHONE: _____ FAX: _____

DATE PROGRAM BEGAN: _____ DATE PROGRAM COMPLETED: _____

RESIDENT CARE AND QUALITY OF LIFE: (A minimum of 200 hours) TOTAL HOURS _____
Topics in this area should include nursing services, social services, food service, medical services, therapeutic services, recreational and activity programs, medical records, pharmaceutical program and rehabilitation services.

HUMAN RESOURCES: (A minimum of 80 hours) TOTAL HOURS _____
Topics in this area should include recruitment, interviewing, employee selection, training, personnel policies, employee health and safety program, and employee retention.

FINANCE: (A minimum of 65 hours) TOTAL HOURS _____
Topics in this area should include accounting, budgeting, financial planning and asset managing, and auditing.

PHYSICAL ENVIRONMENT AND ATMOSPHERE: (A minimum of 40 hours) TOTAL HOURS _____
Topics in this area should include safety procedures, fire, disaster and emergency programs, and building and environmental management.

LEADERSHIP AND MANAGEMENT: (A minimum of 90 hours) TOTAL HOURS _____
Topics in this area should include compliance with laws and regulations and governing entities, risk management, communication, survey, certification, enforcement, quality improvement models and management information systems.

OTHER: _____ **TOTAL HOURS** _____

TOTAL NUMBER OF HOURS IN AIT TRAINING PROGRAM _____

TO BE COMPLETED BY THE SUPERVISING LICENSED NURSING HOME ADMINISTRATOR/PRECEPTOR:
I certify that the AIT whose signature appears below has satisfactorily completed this AIT program of **500** hours as outlined above under my personal supervision.

Provide **a narrative evaluation** of suitability for licensure as a nursing home administrator and **attach**.

_____ _____
(Signature of AIT) (Signature of Preceptor)

GA NHA License # _____

Sworn to and subscribed before me this

____day of _____, 20___,

Signature of Notary Public_____

My commission expires_____ **Notary Seal**

Georgia Board of Nursing Home Administrators

237 Coliseum Drive, Macon, GA 31217 * (478) 207-2440

CERTIFICATION OF PROGRAM COMPLETION - 1000 HOUR PROGRAM

(Please print clearly or type all answers - if there is not sufficient space, use additional sheets and number accordingly).

NAME: _____ Date _____
(Title) (Last) (First) (Middle)

NAME OF FACILITY WHERE TRAINING IS TAKING PLACE: _____

ADDRESS: _____

TELEPHONE: _____ FAX: _____

DATE PROGRAM BEGAN: _____ DATE PROGRAM COMPLETED: _____

RESIDENT CARE AND QUALITY OF LIFE: (A minimum of 320 hours) TOTAL HOURS _____
Topics in this area should include nursing services, social services, food service, medical services, therapeutic services, recreational and activity programs, medical records, pharmaceutical program and rehabilitation services.

HUMAN RESOURCES: (A minimum of 150 hours) TOTAL HOURS _____
Topics in this area should include recruitment, interviewing, employee selection, training, personnel policies, employee health and safety program, and employee retention.

FINANCE: (A minimum of 150 hours) TOTAL HOURS _____
Topics in this area should include accounting, budgeting, financial planning and asset managing, and auditing.

PHYSICAL ENVIRONMENT AND ATMOSPHERE: (A minimum of 80 hours) TOTAL HOURS ____
Topics in this area should include safety procedures, fire, disaster and emergency programs, and building and environmental management.

LEADERSHIP AND MANAGEMENT: (A minimum of 200 hours) TOTAL HOURS _____
Topics in this area should include compliance with laws and regulations and governing entities, risk management, communication, residents' rights, and community services.

OTHER: _____ **TOTAL HOURS** _____

TOTAL NUMBER OF HOURS IN AIT TRAINING PROGRAM_____

TO BE COMPLETED BY THE SUPERVISING LICENSED NURSING HOME ADMINISTRATOR/PRECEPTOR:
I certify that the AIT whose signature appears below has satisfactorily completed this AIT program of **1000** hours as outlined above under my personal supervision.

Provide **a narrative evaluation** of suitability for licensure as a nursing home administrator and **attach**.

_____ _____
(Signature of AIT) (Signature of Preceptor)

GA NHA License # _____

Sworn to and subscribed before me this

____day of _____, 20___,

Signature of Notary Public_____

My commission expires_____ **Notary Seal**

Georgia Board of Nursing Home Administrators

237 Coliseum Drive, Macon, GA 3121 * (478) 207-2440

CERTIFICATION OF PROGRAM COMPLETION - 2000 HOUR PROGRAM

(Please print clearly or type all answers - if there is not sufficient space, use additional sheets and number accordingly).

NAME: _____ Date _____
(Title) (Last) (First) (Middle)

NAME OF FACILITY WHERE TRAINING IS TAKING PLACE: _____

ADDRESS: _____

TELEPHONE: _____ FAX: _____

DATE PROGRAM BEGAN: _____ DATE PROGRAM COMPLETED: _____

RESIDENT CARE AND QUALITY OF LIFE: (A minimum of 750 hours) TOTAL HOURS _____
Topics in this area should include nursing services, social services, food service, medical services, therapeutic services, recreational and activity programs, medical records, pharmaceutical program and rehabilitation services.

HUMAN RESOURCES: (A minimum of 250 hours) TOTAL HOURS _____
Topics in this area should include recruitment, interviewing, employee selection, training, personnel policies, employee health and safety program, and employee retention.

FINANCE: (A minimum of 250 hours) TOTAL HOURS _____
Topics in this area should include accounting, budgeting, financial planning and asset managing, and auditing.

PHYSICAL ENVIRONMENT AND ATMOSPHERE: (A minimum of 250 hours) TOTAL HOURS ____
Topics in this area should include safety procedures, fire, disaster and emergency programs, and building and environmental management.

LEADERSHIP AND MANAGEMENT: (A minimum of 400 hours) TOTAL HOURS _____
Topics in this area should include compliance with laws and regulations and governing entities, risk management, communication, residents' rights, and community services.

OTHER: _____ TOTAL HOURS _____

TOTAL NUMBER OF HOURS IN AIT TRAINING PROGRAM_____

TO BE COMPLETED BY THE SUPERVISING LICENSED NURSING HOME ADMINISTRATOR/PRECEPTOR:
I certify that the AIT whose signature appears below has satisfactorily completed this AIT program of **2000** hours as outlined above under my personal supervision.

Provide **a narrative evaluation** of suitability for licensure as a nursing home administrator and **attach**.

_____ _____
(Signature of AIT) (Signature of Preceptor)

GA NHA License # _____

Sworn to and subscribed before me this
____day of _____, 20___,

Signature of Notary Public_____

My commission expires_____ **Notary Seal**

APPLICANT SIGNATURE & AFFIDAVIT

YOU MUST SIGN THIS AFFIDAVIT IN THE PRESENCE OF A NOTARY

I hereby swear and affirm that all information provided in this application is true and correct to the best of my knowledge and belief. I further swear and affirm that I have read and understand the current state laws and rules and regulations of the Georgia State Board of Nursing Home Administrators, and I agree to abide by these laws and rules, as amended from time to time.

By signing this application, electronically or otherwise, I hereby swear and affirm one of the following to be true and accurate pursuant to O.C.G.A. § 50-36-1:

1) _____ I am a United States citizen 18 years of age or older. **Please submit a copy of your current Secure and Verifiable Document(s) such as driver's license, passport, or other document as indicated on pages 14 & 15 of this application.**

2) _____ I am **not** a United States citizen, but I am a legal permanent resident of the United States 18 years of age or older, or I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act 18 years of age or older with an alien number issued by the Department of Homeland Security or other federal immigration agency. **Please submit a copy of your current immigration document(s) which includes either your Alien number or your I-94 number and, if needed, SEVIS number (See pages 14 & 15 of this application).**

In making the above attestation, I understand that any failure to make full and accurate disclosures may result in disciplinary action by the Georgia State Board of Nursing Home Administrators and/or criminal prosecution.

_____ _____

Signature of Applicant Date

Sworn to and subscribed before me this

_____ day of _____ 20_____

_____ (Notary Seal)

Notary Public Signature

My Commission Expires: _____

NOTE to NOTARY: Application must be signed with Proper ID.

APPLICANT: PLEASE CHECK THE FORM OF IDENTIFICATION BELOW THAT YOU POSSESS. RETURN THIS FORM ALONG WITH A COPY OF YOUR APPROPRIATE DOCUMENTATION.

_____

Printed Name

Secure and Verifiable Documents Under O.C.G.A. § 50-36-2
Issued August 1, 2011 by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 ("IIREA") provides that "not later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law's website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General." O.C.G.A. § 50-36-2(f). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G.A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status.

_____ A United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A driver's license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____An identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at: http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/index.htm [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____An Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A passport issued by a foreign government [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

_____A NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

_____A Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. §50-36-2(b)(3); 22 CFR § 41.2]

_____A driver's license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

_____A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

_____In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document or other form of identification for proof of or documentation of identity, that document or other form of identification will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit. [O.C.G.A. § 50-36-2(c)]